Withdrawal from benzodiazepine dependence

There are various patterns of benzodiazepine (BZD) use. Clearly people taking one tablet a day for years require a different approach from the heavy user under discussion here. There are some cases where BZD prescribing is appropriate to treat a severe anxiety disorder. Hence the patient needs a careful assessment including an evaluation of the reasons for and against use prior to embarking on the management outlined below.

People using high doses of BZDs regularly (e.g. daily) over an extended period of time may experience a withdrawal syndrome when ceasing or reducing their benzodiazepines use. Because of the risk of withdrawal syndrome, benzodiazepines withdrawal requires good planning.

1. PRESENTATION

Benzodiazepine users may present requesting a script for a specific BZD or they may present in a variety of other ways e.g. stating they need BZD's to assist in heroin or alcohol withdrawal, or to treat an anxiety disorder or sleep problems.

2. ASSESSMENT

History

- Drug use: quantity (amount used per day), frequency of use, duration of use, when last used.
- Assess which doctors prescribed how much of which benzodiazepine.
- Features of dependence to benzodiazepines (tolerance, withdrawal, inability to control use despite negative consequences, salience and compulsion).
- Use of other drugs: (e.g. nicotine, alcohol, opioids, cannabis, etc).
- Withdrawal history: successful /unsuccessful. Especially ask after a history of complications – seizures, delirium.
- Home environment and social supports.
- Medical & psychiatric history. Especially conditions predisposing to seizures, anxiety and personality disorders. Anxiety disorders may either be due to the underlying psychiatric problems or due to BZD withdrawal.
- Sleep history, especially if they are using BZDs for sleep.
- Pregnancy.

Examination

- Vital signs (BP, pulse, respiratory rate)
- Evidence of intoxication (drowsiness, sedation nystagmus) or withdrawal from BZDs (see below); other drug use
- Evidence of intravenous injection including groin and neck.

Investigation

- Urinary drug screen may be helpful in confirming the history and excluding other drug use.
- Collateral information
- For a heavy BZD user it is desirable to contact the Health Insurance Commission (with the patient's permission) to obtain a printout of all the medications prescribed to the patient and a list of all the patient's prescribers.
- The patient should be registered as a dependent person with the state Drugs and Poisons Unit.

Withdrawal features

BZD withdrawal is easily confused with recurrence of the underlying anxiety or sleep disorder for which the BZDs were used in the first place. The following are common features of BZD withdrawal:

- Anxiety, insomnia, cravings
- Muscle aches and headaches
- Numbness, tingling, parenthesis, hypersensitivity to noise, light and touch, dizziness
- Impaired concentration and memory
- Depersonalisation and derealisation
- Withdrawal seizures are more likely to occur after abrupt cessation of long-term use of high doses.

The onset and duration of withdrawal symptoms depend on the duration of action of the BZD. Withdrawal of short acting BZD's generally starts within 1-2 days of last use, peak at 7-14 days and gradually subsides. Long acting BZD's generally have a less severe withdrawal starting at 2-7 days, peaking around 20 days, and abate after a few weeks. It is sometimes very difficult to know whether continuing anxiety is due to withdrawal or whether the original anxiety has resurfaced.

CONVERSION table

(These are a rough guide only, start with low doses and titrate upwards).

Clonazepam	Long	0.5 mg
Nitrazepam	Medium	5 – 10 mg
Oxazepam	Short / medium	15 - 30 mg
Temazepam	Short	10 – 20 mg

3. PLANNING WITHDRAWAL

In most cases, BZD withdrawal can be safely completed in the patient's home. BZD withdrawal is protracted and there is little place for inpatient withdrawal, except for those with poly-drug use, uncertain degrees of neuroadaptation, and those with neurological disorders and seizures. Key features of BZD prescribing are:

- Single prescriber with frequent monitoring
- Single dispenser with controlled dispensing, e.g. daily (or second daily) pick up from the pharmacy
- Notifying patients to the Drugs and Poisons Unit
- With the patient's consent the Heath Insurance Commission may be contacted for a printout of the PBS medications prescribed to the patient. If the patient refuses consent the practitioner may decide not to prescribe BZD's.

4. IMMEDIATE MANAGEMENT OF REQUEST FOR BENZOS

- Concerns regarding uncontrolled prescribing include:
- Potential for abuse (including accidental or deliberate overdose)
- Diversion of medication (to friends or black market)
- Delay return of normal sleep pattern (rebound/withdrawal phenomena)
- Potential for the development of dependence
- May mask underlying psychopathology

Some clinics adopt a policy of refusing all requests for BZD's from patients not known at their practice. Another approach for after-hours emergency presentations would be to prescribe enough BZD's to

maintain the patient until their regular practitioner is able to review them. The latter approach reduces the risk of seizures and while discouraging doctor shopping.

5. LONG TERM MANAGEMENT OF BZD WITHDRAWAL

- The key principles to managing BZD withdrawal are:
- Consider contacting the HIC about the patients past pattern of drug use and doctor attendance
- Consider developing a contract of behaviour in which consequences for non-compliance are clearly spelt out.
- Notify the DPU
- Switch to a single long acting BZD, usually diazepam. Dose equivalents are unreliable but if a patient is on a lot of BZDs they will not usually need more than 60 mg per day, usually taken as bd or tds dosing. The aim of treatment is to prevent withdrawals, not to cause intoxication.
- Dispensing medications should be supervised either by a responsible person or picked up daily from the same pharmacy. If a family member is dispensing, consider its impact on the family dynamics.
- Reduce the dose of BZD's by about 10% per week.
- Frequent regular supervision and support is necessary to ensure the patient is reducing comfortably and dealing with the lifestyle and psychological issues often accompanying high BZD use.

Supportive care

- Provide verbal and written information regarding likely withdrawal features and coping strategies
- Supportive counselling from the GP or other health worker (e.g. regional home based withdrawal worker). This includes coping strategies for cravings, maintaining motivation, sleep hygiene and relaxation techniques.

Ongoing Plan

- Relapse is the commonest outcome of most drug withdrawals. On its own, withdrawal treatment is not generally associated with long-term benefits. Ongoing participation in counselling is often required to achieve long-term changes. Consult with DirectLine regarding post withdrawal treatment options.

This information is a general guide for the management of benzodiazepines withdrawal. Consultation with a specialist service (e.g. DACAS) is recommended for patients using multiple drugs or with serious medical or psychiatric conditions. The drug doses given are a guide only and should be adjusted to suit individuals.